

schemes for a specific treatment and indication across different regions, however, is not entirely clear. In the United Kingdom, patient access schemes (PAS) are accepted within submissions to the National Institute for Health and Clinical Excellence (NICE) in England, and the Scottish Medicines Consortium (SMC) in Scotland. We compared guidance published by NICE and the SMC to identify similarities and differences between PAS for the same treatment and indication in these regions. **METHODS:** All NICE technology appraisals published in 2010 and 2011 were reviewed. Treatment appraisals with PAS were identified and the corresponding submissions to the SMC were analysed for the presence and nature of a PAS. PAS were defined as the manufacturer providing a pre-defined reduction in the overall cost of treatment through risk-sharing or rebate schemes. **RESULTS:** In 2010 and 2011, 15 technology appraisals published by NICE included PAS, 13 of which had equivalent submissions to the SMC. Of these 13 submissions, 7 were recommended by both NICE and the SMC, 1 was recommended only by NICE, and 5 were rejected by both. For treatments recommended by both NICE and the SMC, only 3 submissions included a comparable PAS, which consisted of a discounted price in all cases. Of the 4 remaining recommended appraisals, only 2 had a PAS included in the SMC submission, which was a simple discount in both cases. In the NICE appraisals, however, these submissions included more complicated PAS, such as treatment cycle rebates and price matching schemes. **CONCLUSIONS:** There is some alignment between PAS included in submissions to NICE and the SMC; however, where there are inconsistencies the SMC appear to accept more simple discounting schemes.

HEALTH CARE USE & POLICY STUDIES – Health Care Research & Education

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GEOGRAPHIC DISPARITIES IN RECEIVING PREVENTIVE CARE AMONG OLDER INDIVIDUALS

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OBJECTIVES: Older individuals (age ≥ 50 years) should receive higher preventive care to avoid complex health conditions. Rural areas tend to have a higher percentage of older individuals, but lower quality of healthcare. This study examines the geographic variations in the provision of preventive services in the visits made by older individuals to office-based physicians in US in 2009. **METHODS:** Data was derived from National Ambulatory Medical Care Survey (NAMCS) 2009. Visits with individual age ≥ 50 years were analyzed for preventive visits. Preventive visit was defined as a visit where at least one preventive service such as health-education/screening/immunization was provided. The list of preventive services was derived from the preventive services guidelines recommended by 'Institute of Clinical Services Improvement' (ICSI), and 'Healthy People 2020'. Visits outside the Metropolitan statistical area were defined as rural visits. Association between geographic location of physician and preventive visits was examined by performing chi-square analysis using SAS 9.1[®]. **RESULTS:** There were 15,847 visits made by older individuals to office based physicians. The proportion of preventive services provided in rural visits (87.36%) was slightly higher than those provided in urban visits (85.55%) ($p=0.0384$). However, several key screening services recommended by ICSI were significantly lower in rural area. These services may require high-technology investment. These preventive services included; Echocardiography (1.44% vs. 2.98%, $p=0.0002$), Electrocardiography (3.22% vs. 5.47%, $p<0.001$), Pap-smear (0.55% vs. 1.08%, $p=0.0358$), MRI (1.61% vs. 2.48%, $p=0.0224$), Mammography (1.50% vs. 2.37%, $p=0.0189$), and Ultra-imaging (2.27% vs. 3.55%, $p=0.0048$). No significant difference was observed between the geographic location of physician and provision of health-education or immunizations. **CONCLUSIONS:** The lower rate of high-technology screening services in rural area may be due to resource constraints. This concern needs to be addressed to meet the goals of 'Healthy People 2020'. Rural healthcare providers should be well-equipped to increase the screening rates in older individuals.

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COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) UTILIZATION IN TEXAS HOSPICES

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OBJECTIVES: To describe the types of CAM therapies that are frequently offered in Texas hospices. To assess the factors that influence the likelihood that a hospice will provide CAM. **METHODS:** Data was collected via 369 self-administered mail surveys to hospice directors in the state of Texas. Respondents were identified through two national and one state hospice directories and were surveyed irrespective of their setting or geographical location. A total usable response rate of 35.7% was obtained after an initial and one follow-up mail-out. Binary logistic regression analysis was used to assess whether the likelihood of offering CAM was related to the hospice's age, geographic location, agency type, profit orientation, Medicare certification, or number of patients served annually. **RESULTS:** A majority ($N = 61, 56.4\%$) of hospices in Texas provide at least one type of CAM to their clients, with the most frequently offered CAMs being massage (67.7% of respondents), music (61.3%), and relaxation (56.5%) therapies. The logistic regression analysis showed that the profit orientation status and the number of patients served by a hospice were significantly related to the probability that a hospice will offer CAM. Specifically, the odds of offering CAM in 'not-for-profit' hospices were approximately four times higher than in 'for-profit' hospices ($OR = 3.77, p = 0.022, 95\% C.I. = 1.2, 11.8$). In addition, for every 100 patients served by hospices, the odds of offering CAM increases by 13% ($OR = 1.13, p = 0.015, 95\% C.I. = 1.02, 1.25$).

CONCLUSIONS: Massage and music therapies are the most commonly offered CAMs in Texas hospices. CAM provision is related to the number of patients served and profit orientation status, but is not related to other measured characteristics of hospices.

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TRENDS OF EMERGENCY ROOM VISITS VERSUS HOSPITALIZATIONS DUE TO UNINTENTIONAL POISONINGS IN KANSAS CITY, MISSOURI

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OBJECTIVES: To compare trends in emergency room visits versus hospitalizations due to unintentional poisonings in Kansas City, Missouri, from 2001 to 2008.

METHODS: We conducted a retrospective study using Missouri Hospital Discharge Data for Kansas City, Missouri. The data included the causes of emergency room visits and hospitalizations, sex, race, age and zip code. The zip code data were used to categorize the patient's zip code level median family income and to assign the individual to the appropriate local Health Zone. Unintentional poisonings were identified by ICD-9 E-code 850.0 to 869.9. Chi-square tests were used to compare rates of emergency room visits or hospitalizations for each demographic variable. Multiple logistic regression analyses were conducted. **RESULTS:** Unintentional poisonings accounted for 0.4% of the 1,370,453 emergency room visits from all causes and 0.5% of the 496,502 hospitalizations from all causes. Males had the highest rates for both emergency room visits and hospitalizations due to unintentional poisonings. Utilization by age, race, and median family income exhibited opposite trends for emergency room visits and hospitalizations. Persons utilizing emergency departments were more likely to be younger, white, and reside in higher median family income zip codes, whereas hospitalized patients were more likely to be older, black, and reside in lower median family income zip codes. These differences were reflected in the patient's Health Zone of residence. **CONCLUSIONS:** Except sex, trends of emergency room visits and hospitalizations due to unintentional poisonings, were opposite across other demographic variables.

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E-PRESCRIBING TRENDS IN THE UNITED STATES: 2008-2012

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OBJECTIVES: E-prescribing is the electronic transmittal of a prescription to a pharmacy from the point of care. Electronic health records (EHR) provide greater functionality beyond e-prescribing and improve the availability of pharmacy benefits information and patient medication histories. The objective of this study is to describe the absolute growth in e-prescribing, e-prescribing method changes, growth in pharmacies accepting e-prescriptions, and discuss the impact of federal incentives on the e-prescribing adoption rate. **METHODS:** Pharmacy and prescriber data used for descriptive analyses are from SureScripts (12/2008 - 9/2011). Standard descriptive statistics and standard regression analyses were used to analyze the data. **RESULTS:** A total of 95% of all chain, franchise, or independently owned pharmacies in the US route through the SureScripts network. The total number of health care providers prescribing on the SureScripts network has increased significantly over time from approximately 75,000 in December 2008 to approximately 420,000 in January 2012 ($p<0.001$). The number of e-prescribers has significantly increased in trajectory since 2009, which may be due to the federal incentives for EHRs. Health care providers e-prescribing via EHR systems and via stand-alone e-prescribing systems also increased, although the trajectory of EHR prescribers is much higher. Among current prescribers on the SureScripts network, 80% use an EHR. Currently, prescription refills/renewals comprise only 16% of total transactions. The percentage of total physicians e-prescribing on the SureScripts network in the US increased during this study period from 2% to 50%. **CONCLUSIONS:** E-prescribing is the gateway to the improved patient care that health IT promises. Prescription refills/renewals show promising benefits, as they are bi-directional health information exchange. Despite this, physicians have faced many barriers to implementation, with cost and workflow change as the primary challenges. Government incentive programs appear to have increased e-prescribing use among health care providers.

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PHARMACOECONOMIC EDUCATION IN SCHOOLS AND COLLEGES OF PHARMACY IN 2011 IN THE UNITED STATES

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OBJECTIVES: The growing need for pharmacists to monitor and assess economic and health outcomes associated with pharmacy products and services provided is reflected in the most recent US Accreditation Council for Pharmacy Education (ACPE) guidelines (effective 2007). The last investigation of pharmacoeconomic (PE) education in US colleges of pharmacy (COP) was conducted in 2007 (before the new guidelines came into effect). The objective was to conduct a follow-up survey in 2011. **METHODS:** E-mails requesting syllabi covering pharmacoeconomic topics were sent to all US Colleges/Schools of pharmacy who had PharmD graduates in 2011 ($N = 103$). A follow-up e-mail was sent to instructors who provided these syllabi asking for 1) the number of students who completed the course; 2) the availability of pharmacoeconomic projects; 3) if there were PE rotations available for PharmD students; and 4) the opinion of the instructor about the sufficiency of the hours devoted to pharmacoeconomic education. **RESULTS:** The majority of the colleges and schools (78 out of 87 analyzed) covered PE in required courses. The number of hours dedicated to pharmacoeconomic-related topics varied from 2 to